Utah Department of Health
Prevention, Treatment and Care Program
TB Consultant Request for Statement of Qualifications

The Prevention, Treatment and Care Program seeks to procure medical consultants for adult and pediatric tuberculosis management for calendar year 2019 (January 1, 2019 through December 31, 2019). Qualified individuals will be added to a state-wide closed-ended approved vendor list.

I. Application Process

A completed Statement for Qualifications must be submitted to the Program by **November 30, 2018**. The Program will notify approved vendors by December 20, 2018. Please submit completed statements to:

Prevention, Treatment & Care Program
Utah Department of Health
Attn: Amelia Self
P.O. Box 142104
SLC, UT 84114-2104
aself@utah.gov

II. Minimum Mandatory Requirements

Vendor(s) must meet the following minimum mandatory requirements:

A. Current Utah medical license;
B. At least 5 years' experience of management active tuberculosis disease and latent tuberculosis infection; and,
C. Board certification in pulmonology and/or infectious disease.

III. Approved Vendor List

A. Vendor(s) who 1) submit a responsive statement of qualifications **and** 2) meet the minimum mandatory requirements and evaluation criteria will be added to the Approved Vendor List.
B. Vendor(s) included on the Approved Vendor List are the only entities authorized to participate in the TB Medical Consultant procurement.
C. Vendor(s) may be removed from the Approved Vendor List due to failure to meet the requirements set forth in the application and/or failure to maintain a current Utah medical license and/or poor performance as documented by the Program.

Instructions:

1. Vendor Information-please provide the requested information.
2. Vendor Qualifications-please provide a written response to questions 1-5. Responses should be thorough and concise.
3. Vendor Payment-please provide written indication of Yes or No to each question.
4. Sign application.

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Vendor Information:
Name:
Federal Tax Identification Number or Social Security Number:
Address:
Phone Number:
Email:

Vendor Qualifications:

1. Is the Vendor licensed to practice medicine in the State of Utah?
   If yes, please provide medical license number and copy of current license.

2. Does the Vendor have experience managing active tuberculosis disease and latent tuberculosis infection?
   If yes, **please describe experienc**e; description should include 1) number of years of experience managing tuberculosis; 2) training/certifications; and 3) number or years of experience working with Utah Department of Health, local health departments and private providers.

3. Is the Vendor available to provide state-wide consultation services?
   If yes, please describe availability including days of week, hours and availability for after-hours consultation. Please also describe mode of availability (e.g. phone, email, in person, etc).

4. Is the Vendor willing and able to participate in the bi-annual TB Cohort Review? (Requires attendance at a four (4) hour meeting twice a year.)

5. Is the Vendor willing and able to participate in bi-monthly Chest Clinic at Salt Lake County Health Department? Requires consultation services for four (4) hours on the first and third Wednesday of each month.

Vendor Payment:

1. Does the Vendor accept the hourly consultant rate of $100.00?
2. Is the Vendor able to invoice the Program on a monthly basis?

_____ _____
(Signature) (Date)

Printed Name:	
Title:	

UDOH Evaluation Criteria:

1. **Licensing**: The Vendor shall maintain licensure with the Utah Department of Commerce, Division of Occupational and Professional Licensing at all times while providing services under this agreement.
2. **Experience**:
    a. The Vendor must demonstrate a minimum of **5** years of experience managing active tuberculosis disease and latent tuberculosis infection.
    b. The Vendor must have board certification in pulmonology and/or infectious disease.
    c. At least one selected Vendor will be a pediatrician board certified in pulmonology and/or infection disease.
    d. The Vendor must demonstrate daily availability (M-F, 8:00-5:00); after hours; bi-monthly Chest Clinic; bi-annual TB Cohort Review; and as needed.
3. **Payment:** The Vendor must demonstrate acceptance of the standard consultant rate and have an ability to invoice the Program on a monthly basis.